John Grey

Feb ~~1899~~ 1900

1899
20

William Williams aged 59 Brickmaker

Admitted 22-11-99 Died 26-12-99

Parents both dead, causes unknown. Patient could give no history of the other members of the family

Previous Illness

Had "venereal disease" when about sixteen years of age & some years ago had "inflammation of the kidneys". At that time he was ill for three months

Social Habits

Patient is unmarried & admits that he has been very intemperate in fact he spent most of his wage, which was about 36/- per week, in drink & horseracing. For the past eight weeks however he has been "on tramp" and as a result has not been getting either good or sufficient food

Present Illness

Took ill suddenly at 11 A.M. on November 19th with some dry retching and much diarrhoea. The throat felt as if it were thickened and the appetite was lost. Next day a cough came on, with acute pain in the right side of the chest and some shivering. There was no headache or vomiting. He had some spit, yellow in colour & was very thirsty

On the 21st the patient felt much worse. The cough was more persistent, the spit more profuse & the shivering worse

Patient attributes his illness to the fact that on the 18th that is the day before he became ill

he was rather lightly clad and the day was cold & foggy. He did not get wet at all but felt chilly most of the day.

Condition on admission

Patient complains of pain in the right side of the chest, the breathing is accelerated about 36 per minute & is rather shallow. There is an irritating cough and a spit which is scanty, rusty & tenacious towards afternoon, however, on the day of admission it became much more copious, darker in colour more frothy and less tenacious. There is no headache. The appetite is gone but thirst is a marked feature. There is no appearance of herpes on the lips. The tongue has a moist thick yellow coat. There is no vomiting and the bowels are not loose. There is a slight perspiration all over the skin. The pulse is about 98 per minute, of good volume though somewhat soft. The heart sounds are normal. The temperature is 102·8. There is the existing of a chancre on the glans penis.

Examination of chest

Inspection gave negative results except that if anything the movement on the right side was not quite so free as on the left side. This was probably due to the pain.

Palpation revealed nothing.

Percussion showed some dullness of the right lower lobe laterally apparently over the lower border of the lung. The dullness moreover was not well marked.

Auscultation of that area showed nothing characteristic. The respiratory murmur was

to a great extent obscured by moist bronchial
rales which were fairly universal over both
lungs
Nov. 23. The patient slept well last night but
today he complains of pain about the right nipple
& there was found there a limited area of dulness
The respiratory murmur was much weaker than in
the surrounding tissue. The respiratory murmur
over the whole of the right lung anteriorly is
distinctly weaker than on the left side. Today the
rales on the left side have disappeared to a
great extent and those on the right have become
dry in character. The dulness in the right
side of the chest does not seem to be altered in
any respect. Patient has been drowsy today but
not delirious. There has been some diarrhoea
Nov. 24 Patient slept well last night The bowels
moved twice during the night, the motions were
relaxed and light brown in colour. This morning
there does not seem to be any alteration in the
chest condition The patient looks much better and
the pain complained of yesterday in the right chest
is absent now The motions are still relaxed.
In the evening the patient complained of the
pain recurring again in the chest & also of
breathlessness. Auscultation over the painful
area showed, at the end of inspiration, fine
dry crepitation. This was taken to indicate
some extension of the inflammatory process & this
was afterwards proved to be the case
There is a very slight expiratory rattle in the
throat.

Nov. 25th The area of consolidation was increased very considerably. The whole lobe, the posterior part of the middle lobe and the lower lobe showing dullness throughout. Pure tubular breathing is heard over the upper lobe but over the lower lobe the breath sounds are not so well marked being replaced by coarse moist rales. The expiratory puffle is not nearly so well marked today nor is the face so flushy as it was yesterday. The spit is still purulent and becomes more copious

Nov. 26 "During last night the patient had very little sleep. His breathing was loud and he was very restless but not delirious. The bowels moved five times. This morning he looks more exhausted. Face is flushy but pulse fairly good. Oxygen was given and had some temporary success but the patient ultimately refused it. Late in the afternoon the pulse began to fail and death took place towards midnight. Consciousness was present up to the last.

Treatment.

This at first consisted of an iodine mixture with Ipecacuanha as the disease advanced he was put on a stimulating ammonia mixture. Inhalations of oxygen were given on the day he died. Nothing was given for the diarrhoea.

Post Mortem Examination

Body well nourished

Dark serous frothy fluid oozing out of the mouth.

There is a considerable layer of subcutaneous fat. There is about twelve ounces of clear serous fluid in the right pleural cavity. The right lung is adherent to the chest wall by numerous recent bands easily broken down. The lung is removed with difficulty owing to its being practically solid throughout. The three lobes are adherent to each other by recent layers of fibrin. The upper lobe is solid throughout and is greyish in colour
The middle lobe is in a similar condition except towards its anterior border where the lung tissue was normal but very oedematous, clear frothy fluid could be pressed out in abundance
The lower lobe was solid throughout but the solid matter was softening and towards the lower and anterior margin the lung tissue which could be easily broken down was filled with purulent looking frothy fluid which could be squeezed out.
The left lung was almost universally adherent to the chest wall by old firm adhesions and had to be partly cut out of the chest, it showed in great part a leathery appearance like a lung long compressed by fluid, but otherwise appeared normal

Heart

The right side was filled & distended by clotted blood. Both in the auricle and the ventricle there was a firm antemortem clot.
The tricuspid valve was ~~healthy~~ normal
The left heart was practically empty but in the ventricle there was an antemortem clot which

sent a moderate dilatation into the aorta
The aortic valves appeared to act well at
the heart muscle was firm & healthy. There was
no pericarditis
Stomach & bowels were empty of solid matter
but were slightly distended by gas.
There were some haemorrhagic spots on the mucous
surface of the stomach
The liver was very little but was normal in
size. It showed much fatty degeneration
The kidneys were normal in size but somewhat
congested and the epithelium was granular
Spleen The substance was semi fluid and of a dark
brownish red colour. The organ was normal in size

Having now described a case in detail I shall
proceed to deal with the various points which
are prominent in it
The cases I have had for the study of this disease
have all been found in one of the largest poor-law
infirmaries and the patients have been drawn
from a selected class namely paupers and they
bring out a few facts of interest
In the first place pneumonia is an extremely
common cause of death among paupers, as during
the past seventeen years there have been in this
infirmary a total of 3,469 deaths of which no less
than 469 or 91·6 per thousand are due to pneumonia
Not only does the pneumonia death rate stand high
in relation to the death rate from all causes but
the proportion of deaths to recoveries is also high
In 142 cases that I examined no less than fifty seven
deaths took place giving a death rate of 40 per hundred

The deathrate in voluntary hospitals from pneumonia is usually given as from 20% — 30%
This increased mortality among paupers is due chiefly to three causes
Firstly, in their infancy most of the patients are brought up in poverty and a good foundation cannot be laid so as to withstand any attack of acute illness at a later period of life
Secondly, the intemperance of the average pauper is appalling; out of 142 cases thirty state that they are temperate in their habits, six gave no information as to their drinking capabilities, and the remainder 106 in number are classed as intemperate. Some of them when in regular work would spend at least ten shillings per week on drink. The usual rule is to spend the surplus money on drink
The third cause is that a great number of these cases are single men who reside in private lodgings or common lodging houses, and their food is often bad in quality & insufficient in quantity so that from these three causes working together pneumonia among paupers is a very fatal disease

The months from December to June inclusive are those in which the greatest number of deaths take place and of those months March is the heaviest as will be seen from the following table which is an analysis of the deaths from Pneumonia in this hospital for the past eighteen years.

	Jan	Feb.	March	April	May	June	July	Aug.	Sept	October	Nov.	Dec.
1882	1	1	3	4	2	0	1	1	0	2	1	3
" 83	2	0	1	0	0	0	1	3	1	2	0	1
" 84	3	3	2	1	3	4	2	4	1	0	0	1
" 85	1	1	2	0	1	3	1	1	1	2	2	5
" 86	0	1	4	2	3	1	0	2	0	1	0	2
" 87	1	2	3	1	1	2	2	1	3	1	2	0
" 88	2	6	2	7	7	4	0	1	1	4	0	4
" 89	3	0	2	8	7	4	1	0	0	2	4	11
" 90	7	9	24	7	3	1	2	3	2	1	3	4
" 91	3	4	3	1	3	2	1	1	0	0	1	1
" 92	2	2	3	5	0	0	1	1	2	1	0	3
" 93	2	0	2	4	3	3	0	0	2	0	1	3
" 94	4	1	2	2	4	0	1	0	1	0	0	1
" 95	3	1	3	1	3	1	3	0	2	3	1	2
" 96	2	1	2	0	2	4	2	0	2	1	3	0
" 97	2	2	3	5	6	3	1	2	3	4	0	0
" 98	1	4	1	6	3	3	3	1	2	0	1	1
" 99	1	6	3	3	4	1	1	3	4	1	1	2
Total	42	43	71	57	61	38	23	24	27	25	22	44

The diminished mortality in the months of July to November inclusive being very marked being practically about one half of the number of deaths in the other months.

August is the month with the fewest deaths these figures correspond with those given by the Registrar General as to the months of maximum and minimum death rate from pneumonia

During two complete years we have had 114 cases and it is seen from them that January, March &

April are the months in which most of the cases occur. and that in July August and September very few cases occur.

January	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
14	9	17	17	12.	11	3	2	3	12	9	5

= 114

The cases coming under my notice varied considerably in age ranging from 3 to 73 years. The age distribution of 142 cases is as follows

Age periods	1 — 5	5 — 15	15 — 25	25 — 35	35 — 45	45 — 55	55 — 65	65 — 75	75 — 85
Cases	3	3	14	33	45	25	14	5	0

By far the greater number of cases were men in fact only five females came under my notice I do not however, for a moment, put this forward as an example of the frequency of the disease in the sexes as the majority of acute cases of illness amongst the patients admitted here are men There is no doubt however that pneumonia is much more common, in the lower classes, amongst men than women owing chiefly to the different occupations. The men being much exposed to weather and other depressing circumstances whilst the women are for the most part employed in the Factories

Cause.

In the great majority of cases the patients attribute their illness to exposure to inclement weather or to getting wet. In only one case did I meet with, so far as I could judge, a case of direct infection. This was the case of C. R 24

who had been nursing and sitting up at night with his brother who was ill with pneumonia and who died on 22-5-99.
Five days later on the 27th C.R. had rigors and was compelled to go to bed on account of feeling so very unwell and on being brought here four days later showed a fully developed apical pneumonia in the right lung
In no case could I get a history of injury as a cause nor inhalation of any irritating vapours but in one case Pat. G. 54 the patient attributed his illness to the fact that just previously to taking ill he had been working over a newly opened sewer and he thought that the sewer gas had had something to do with it. At the same time he admitted that he had been exposed to wet weather while working at the sewer It is probable here that both circumstances had to do with the causation of the disease
In some of the cases no cause could be thought of.
The relation of pneumonia to meteorological events is very close indeed I was well shown in some of the cases. Whenever wet, cold and changeable weather prevailed then it was followed by a series of cases of the disease Cold weather by itself produced very little effect but when the diurnal range of temperature was great as in spring then we had the greatest number of cases.
I paid particular attention to this point with those cases which occurred in the summer months and I noticed that those days with a

considerable amount of sunshine, and which, therefore were warm, and some of them were particularly so, but which were followed by an east or North east wind, these days then were followed by a few odd cases of the disease
I noticed this markedly in two cases where for some days we had been having a south west wind and then suddenly it veered round to the north east and a few days later these cases were admitted stating the beginning of their illness & the date at which the north east wind came
These cases more that meteorological events if not the sole cause of the disease at all events play an important part in the causation of it at least in those cases which are not directly due to infection on the other hand the well marked course of the disease and its usually well defined boundaries lead one to the conclusion that in addition to exposure to cold & wet a specific micro-organism is required for the production of the disease and such a micro-organism can be found in the spit of practically every case in the form of the Streptococcus Pneumoniae
Initial Symptoms and Signs
The usual history was that the illness commenced with extreme suddenness. The patient might be walking about or might have been working all day and on the way home at night he shivered and became sick & could not take his food or he may have gone to bed all right and awoke at the middle of the night with rigors & would be unable to go

D work next day, Frequently the onset was accompanied by pain more or less severe in the chest and pain irritating troublesome cough. The temperature was usually high but as I am dealing with this point by itself I shall leave it at the present.

The spit might come on at the very outset and consist of clear tenacious mucous simply or it might be streaked with blood.

In my experience however the spit made its appearance more often on the second or third day of the disease. Sometimes there was at this stage no spit at all

The pain referred to above was sometimes simply confined to that part of the chest over the area of lung affected but often it would be reflected all round the side of the chest and sometimes even it was complained of in the abdomen in the region of the epigastrium

The onset in other cases was not nearly so well marked and considerable difficulty was found in fixing the actual day and in some cases it was altogether impossible to give any precise date. For instance Joseph B aged 49 a heavy drinker all his life was admitted on 16-9-99 complaining of pain in the lower part of the left chest and stating that he had not been well for the past two weeks. He had had rigors on three separate occasions namely on the 6th - 8th and the 9th and then after an interval on the 15th they returned accompanied by vomiting. Next morning the 16th.

he was unable to take breakfast and felt so unwell that he had to return to bed. On his admission that same day he complained of pain in the left side and over the seven ribs of that lung. He was marked dullness. The case terminated fatally on 20·9·99.

Headache was another prominent feature in some of the cases at the onset but usually it passed off in about forty eight hours but occasionally it was very persistant

Vomiting was also common. It usually occurred on the first day and was absent afterwards In any case when it occurred the act of vomiting simply took place once or twice and just about the same time as the rigor

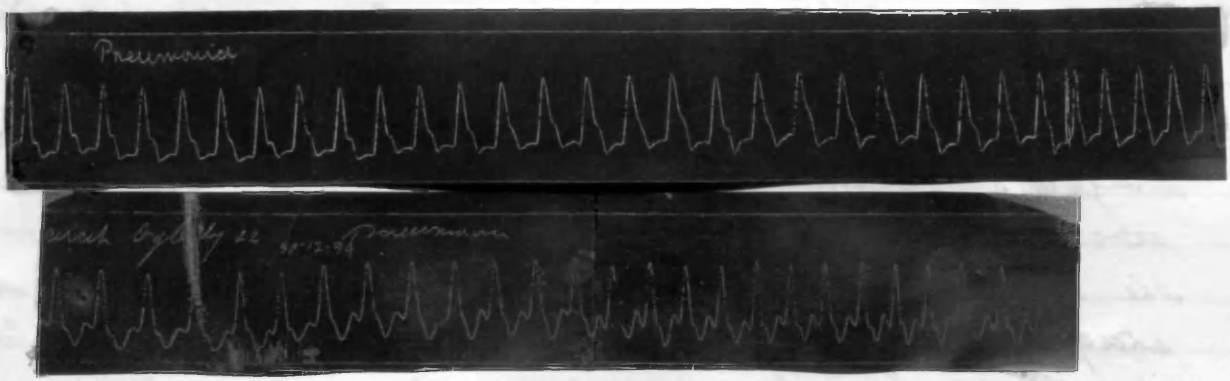
I only observed delirium among the initial manifestations once and in this case it came on the first day & continued right through until the fatal termination on the seventh day.

In the few cases which I was fortunate enough to get from the very beginning the first noticeable alteration of the respiratory murmur was that it seemed to be harsher and more like puerile breathing and then fine crepitation came on

The blood showed some considerable increase in the number of leucocytes. The respirations numbered about 30 per minute and the pulse rate 80

The tongue was moist and covered by a thick creamy fur. The movement of the chest wall might be less extensive than on the healthy side particularly if pain was present. The bowels as a rule were inclined to be costive. This stage passed on quickly to the second stage namely that of Consolidation and during this period in a well marked case the usual

appearance prevailed. The face would be flushed as a whole or it might be that both cheeks only were affected or the flushing may be confined to the cheek corresponding to the lung affected. The breathing is shallow, hurried and sighing. The tongue becomes dry and brown and partially creamed. The skin may be moist but more often it was as dry burning feel. The bowels were usually costive although in some of the cases diarrhoea was marked as it was in the case given in full length at the beginning. In cases where a large area of lung was involved the eyebrows would be raised and the alae of the nose dilated at each inspiration. Ultimately I began to dread the appearance of these two signs, as the cases which showed them almost invariably died. The urine in this stage was usually diminished in quantity and loaded with urates often showed a quantity of albumen the chlorides I did not estimate. Delirium at this stage was practically present in every case. Sometimes it would be slight and quiet in character and consist mostly of wandering in the speech. At other times it would be more pronounced and the patient would be always wanting to get up and do some other acts and still more violent and had to be held in bed practically by force. One patient who was practically moribund, but had been previously of this rather troublesome, and was thought to be incapable of doing any injury to himself in the temporary absence of the nurse got out of bed took a short run and a header through the window which fortunately was only a few feet above the ground but he was picked up, placed outside
Examination of the lung at this stage revealed usually the classical signs but not always as instead of


Pneumonia

the vocal resonance being increased in some cases it was diminished and the respiratory murmur could only be heard faintly. This was particularly so if some pleuritic fluid intervened between the lung & the chest wall. The chest wall as a rule was enlarged over permanent. The percussion note over the seat of lung unaffected & noticed occasionally to be accompanied by metallic quality. During the height of the fever the respirations are much more rapid than in the reconvalescent stage. In one case, which however recovered, they reached 64 per minute while the pulse in the same case was 100. As a rule the respirations ranged from about 38 to 48.

The pulse was shown by the sphygmograph to be characteristic and in some instances markedly so. (See appendix page)
The pulse varied considerably ranging from normal up to 156 a minute. When the case was terminating fatally the pulse instead of being full strong & forcible became smaller in volume less regular and ultimately fluctuating in character so that it was impossible to count it. The pulse seemed to depend upon several factors. 1st as to the condition of the heart itself, as to the efficiency or otherwise of the valves; as to the existence of any pericardial adhesions 2nd as to the height of the temperature. As an instance of the first case where rapidity of the pulse was due to a diseased heart let me instance the case of T.T. who had been an inmate of the infirmary for some months owing to an attack of hemiplegia and in whom both the mitral and aortic valves were defective from the very beginning of his illness from pneumonia the pulse ran along at 140 per minute until death took place. There is no definite relation between the pulse rate and the height of the temperature as in

cases where the temperature was 103 the pulse was running at from 80 to 100 per minute. In another case where the temperature ran along the normal line the pulse ranged at from 100 — 128 This was in the case of a woman aged 73 as a general rule however when the temperature ran up the pulse rate increased and I have noticed several instances where the rise in temperature was announced by an increased pulse rate The pulse respiration ratio was usually about 1 — 2·4 In one case it came as low as 1 — 1·4 In the second stage of the disease in some of the cases sleeplessness was a prominent feature
Distension of the bowel with flatus was observed occasionally and in one case it was very extreme so much so as to greatly interfere with respiration and I have no doubt contributed greatly to the fatal termination
The spit during this stage showed the usual appearances. When the crisis arrived a marked difference was at once noticed in the patients a patient that may have been delirious and sleepless now falls into a quiet sleep.
Sweating was common at the time of the crisis or a few hours previous to it I did not observe any critical diarrhoea or any decided increase in the quantity of urine excreted. In the case quoted at full length at the beginning there was unfortunately no opportunity for watching the crisis
The pulse as a rule underwent a rapid change It slowed down at almost as rapid a rate as the temperature fell In the case of Ed. 2 40 the temperature fell in about 12 hours a to from

107° D 97.5 and during the same time the pulse rate fell from 104 D 76 per minute
The respiration rate does not however show such a marked fall. In the case of Bd. 2. at the time of the crisis the respiration rate only fell during twelve hours from 40 D 36 per minute and it took about ten days before it became normal
In another case it was 16 days after the temperature fell before the respiration rate became normal. About two weeks was a very common period of time to elapse before the respirations became normal. In only very few cases indeed did they become normal under one week. This clearly indicates that the rapidity of breathing does not depend so much upon the temperature as upon the extent of lung involved and improvement in the condition of the lung itself must precede improvement in respirations
In any given case when the rapidity of the respirations underwent a progressive change that is when the rate became quicker the case usually terminated fatally.
The appetite after the crisis usually returned speedily and in the young & strong convalescence was rapid but in the majority of the cases convalescence was slow and protracted
Complications
One of the most important that took place was premature labour This was in the case of Rab O. 22 who was six months pregnant and who was confined on the fourth day of the illness ~~from~~ caused by pneumonia. The case ended fatally on the fourteenth day.

In no case did I meet with an emphysema following pneumonia. In another case where the lung did not recover quite thoroughly the patient returned in about six months with well marked phthisical signs in the area where the inflammatory mischief had been. In the case of a child the pneumonia was followed by Whooping cough the course of which was unaccompanied. Meningitis occurred in another case which apart from that had been favourable but which ended fatally. During life I never detected any evidence of pericarditis in any case. In one case the pneumonia presented an affair assumed to be an attack of acute rheumatism. The patient M. D. 29 came in complaining of severe pain in several of the joints of a few days duration. There was also slight cough hyperpyrexia was a marked feature the temperature reaching on two occasions 106°. About two days after admission some dulness was noticed in the middle part of the lower lobe of each lung The case terminated fatally in about 36 hours afterwards and the lungs on examination were seen to be in a state of red hepatization in the parts corresponding with the dulness.
I did not meet with any case when gangrene of the lung supervened
Cardiac murmurs I noticed fairly often during the height of the disease
Treatment

This was my simple and as a rule was somewhat as follows If pain were present poultices were applied until relief was obtained A simple saline mixture was ordered. When the pulse

began I show any signs of weakness a stimulating ammoniacal mixture was substituted with or without digitalis or nux vomica as the case required. I have noted most beneficial results from the administration of these two drugs Alcohol was never administered as I believe it to be the great cause of pneumonia and moreover any degree of stimulation required could be produced by the ammoniacal compounds

Post mortem notes.

I only met with one case of double pneumonia and that was in the case of M.D. already reported 2. The affected areas varied considerably in size from the total consolidation of an entire lung down to tiny patch about two inches in diameter. In this latter case the consolidated area was situated on the upper margin of the right lower lobe and was in the case of an old patient aged 68
Pleurisy was present in every case and in one or two the layers of fibrin were excessively thick.
Pleural effusion was marked in some cases eight ounces of clear serous fluid being found in one case. Another showed much more but unfortunately it was not measured.
It was remarkable that I did not meet with a case in which the non infected lung could be passed off as healthy.
Emphysema was an extremely common disease affecting it in other cases it would have no pleural covering and would require to be

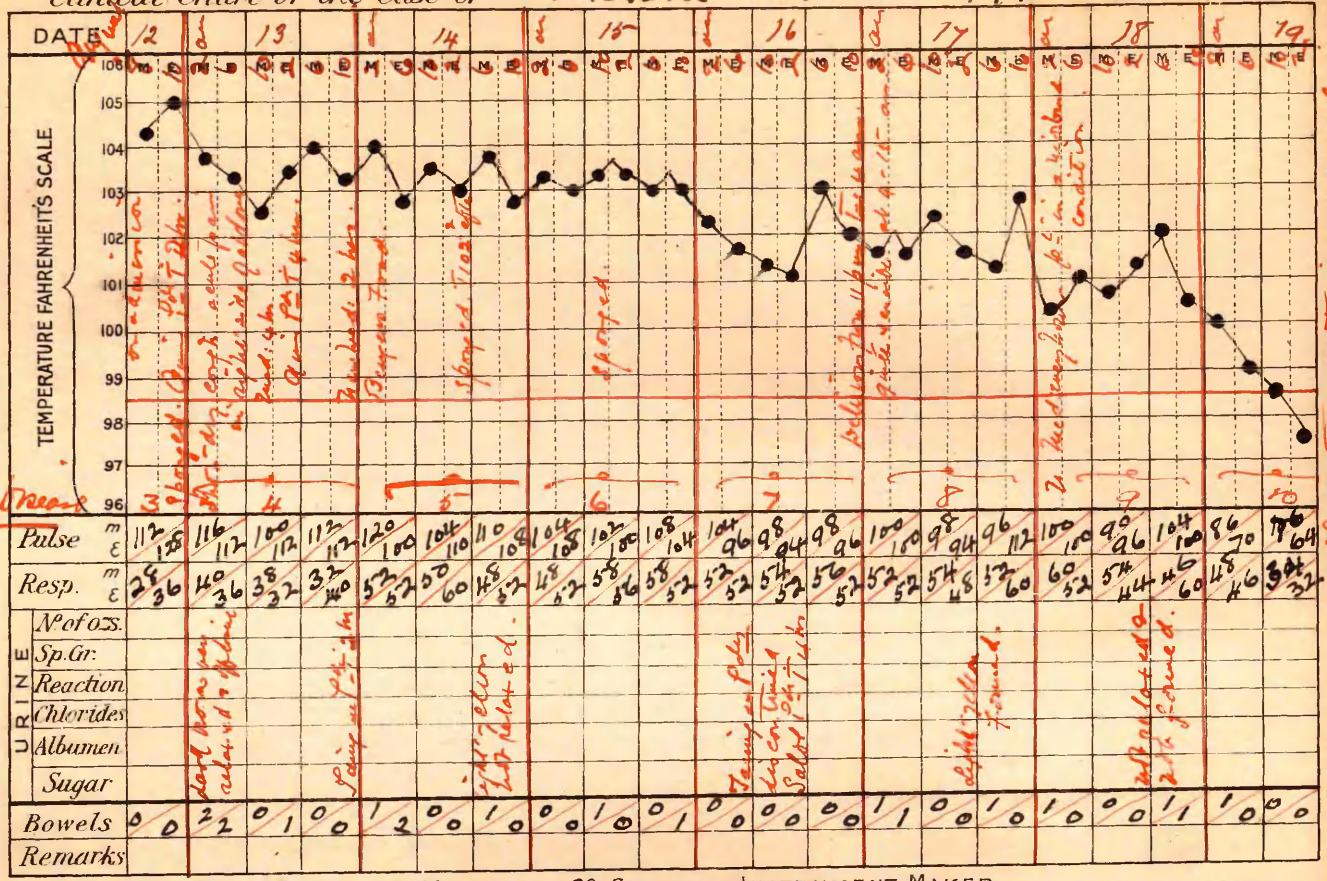
cut out of the chest In addition to that it was usually exclamatory and some cases were markedly so In one instance I have made the note that the parts of the lungs free from pneumonic consolidation resembled wet sponges so much fluid could be pressed out of them.
These cases make one wonder if there is no possible means of draining away the fluid which is simply drowning the patient
The pericardium showed slight ecchymosis in two cases.
The right heart as a rule was distended and filled with dark clotted blood
The left heart was usually empty
In every case there were white ante mortem clots, very firm in character, adherent to the heart walls or entangled in the columnae carneae. Often the auricular appendages would be filled with a clot of this character
The liver invariably showed fatty degeneration
The kidneys often were much congested and showed epithelial degeneration of the epithelium. In one case there were two recent haemorrhagic infarctions
The bowel as a rule presented nothing worthy of notice. In two cases flatulent distension was present to a great degree
The mucous coat of the stomach in several cases showed haemorrhagic points
The Spleen was usually normal in size but the pulp was much softer in the cases given at the beginning it was semi fluid

I repeatedly examined the sputum bacteriologically and invariably found some difference. In one case however I found a small rod shaped bacillus. I made the following note concerning it. Gelatine streak or plate cultivations show pure cultures of a minute rod shaped bacillus much smaller than the typhoid bacillus. Colonies are pointed & transparent, pursued above the surface of the gelatine and appear to be granular when examined by the low power of the microscope. The organisms stain well by Fuchsine but not by Grahms method. In stabs they produced a feltwork growth. The lancing discharge showed some of the bacilli to be motile & others in a resting condition. In short it gave all the characteristics which Klein describes in his description of the bacillus which he discovered in the lesions of Middlesbrough specimens of pneumonia and to which he attributed the disease

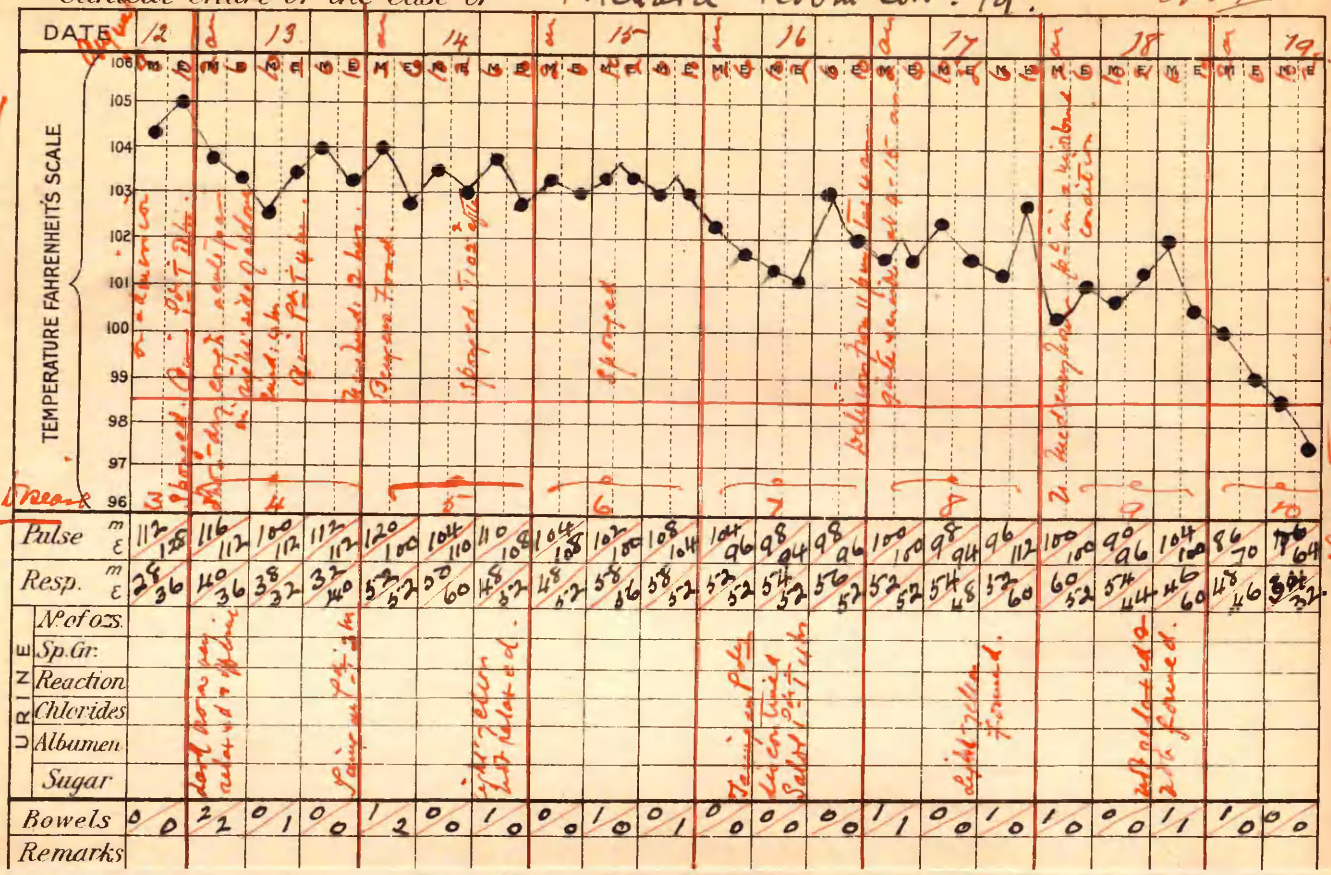
Temperature

This presents so many points of interest that I have kept it to be specially dealt with by itself. In looking at a chart of a case of Pneumonia there is nothing absolutely pathognomonic about it as taking even a typical one where a well marked crisis occurs after several days of sharp fever such a chart might only represent a case of erysipelas. During the course of a case of Pneumonia the temperature gives a fairly reliable guide as to the severity and as to the supervention of complications and as to the certainty of recovery. In other diseases such as measles or whooping cough when pneumonia is set to

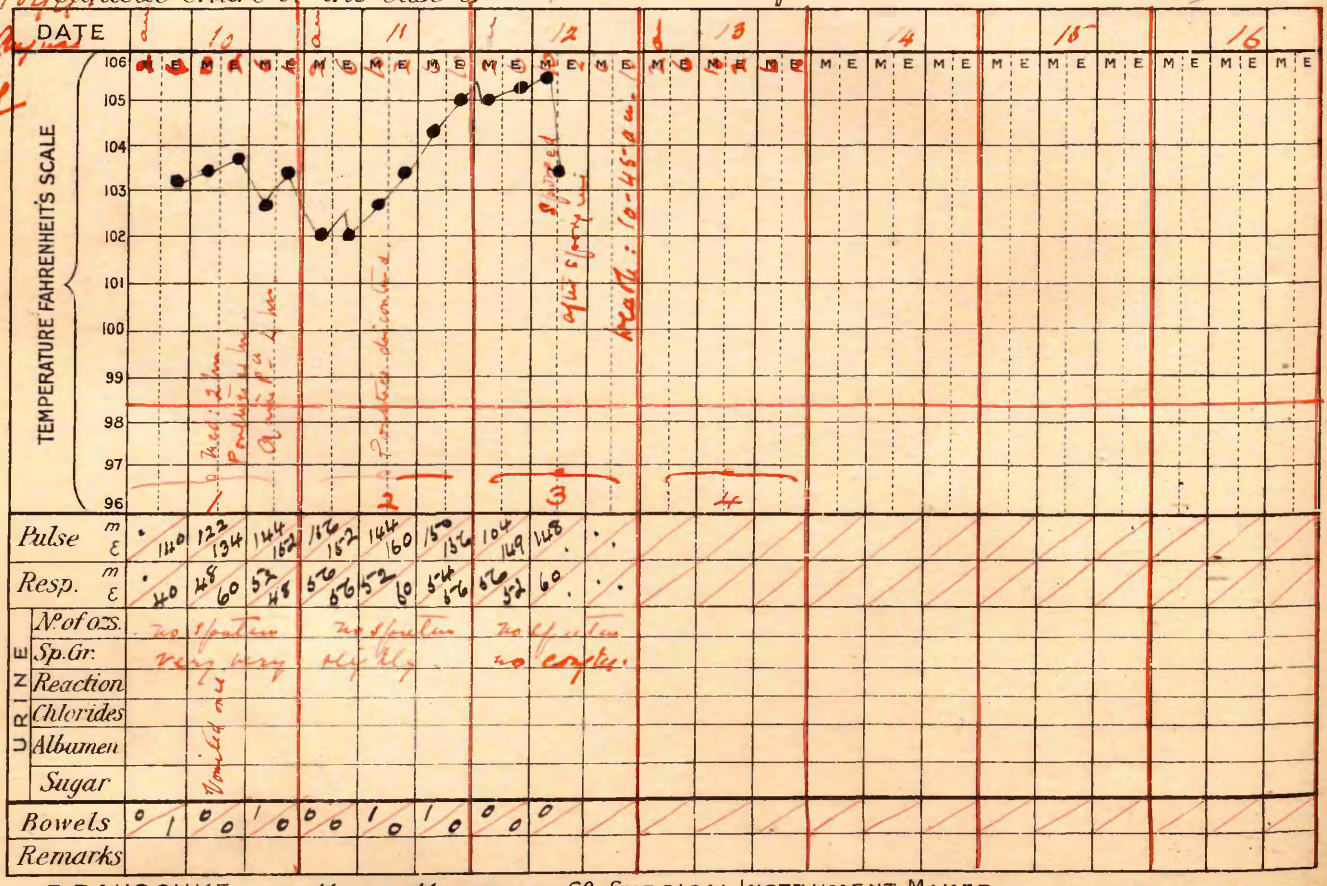
Clinical Chart of the case of Richard Robinson. 19. No I



Clinical Chart of the case of Richard Robinson. 19. No I



Clinical Chart of the case of Thomas Thompson. 38 No II



supervenes as a complication the temperature is of the greatest importance as indicating by an abrupt elevation the onset of the pneumonia. I shall now deal with a fairly typical case Richard R. 19 W.S.I. admitted on 12-8-99 complaining of severe pain in Right Chest and sore throat. He had become ill two days previously.
On admission his temperature was 101.6° and for the next three days it ranged between 103° and 104°. On the 16th that is seven days after he became ill the chest began to be more involved, the temperature began to fall somewhat. For next two days showed still some irregularity but on the evening of the tenth day of the disease the temperature fell down twelve hours from 102° to 98°. and continued normal afterwards.
In this case I had not the opportunity of studying the beginning temperature as he was not admitted until the second day of disease so I must refer to others for that point. J. C. aged 38, Chart No 2) who had been in the hospital for some time owing to an old attack of Hemiplegia, on the morning of August 9th he was in his usual health, in fact felt well all day and had a normal temperature on the morning of the 10th he was feeling ill and the temperature was found to be 103°. This case ran through the usual course & ended fatally
Again Pat. M. 56 (Chart No.3) admitted on the first day of disease and the temperature was found on his admission at 9 a.m. to be 101° and at two p.m. it had run up to 105°. This case had been

Clinical Chart of the case of Patrick Maxwell 56.

DATE 20 21 22 23 24 25 26

TEMPERATURE FAHRENHEIT'S SCALE 106 105 104 103 102 101 100 99 98 97 96

Pulse m / ε

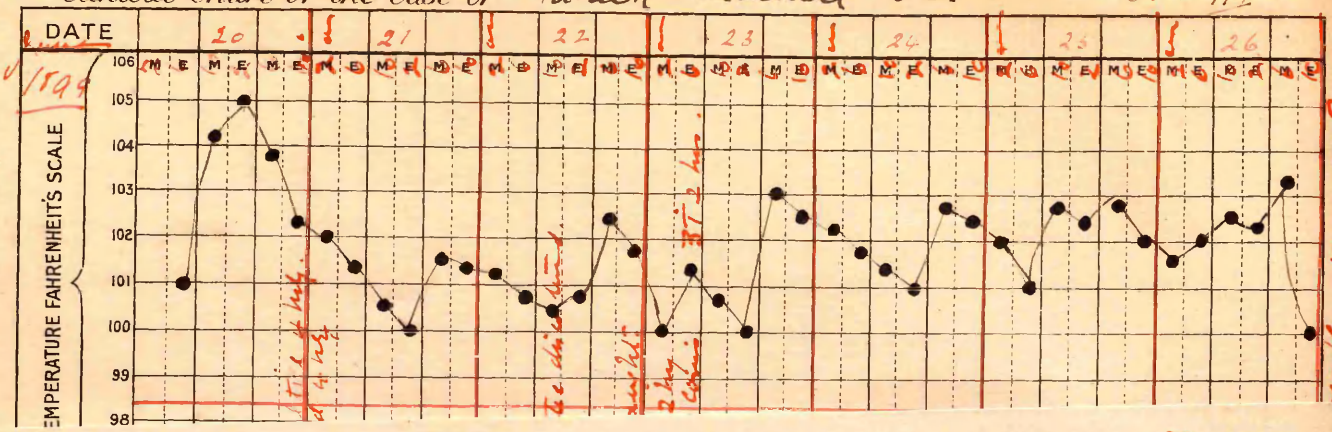
Resp. m / ε

URINE
No. of ozs.
Sp. Gr.
Reaction
Chlorides
Albumen
Sugar

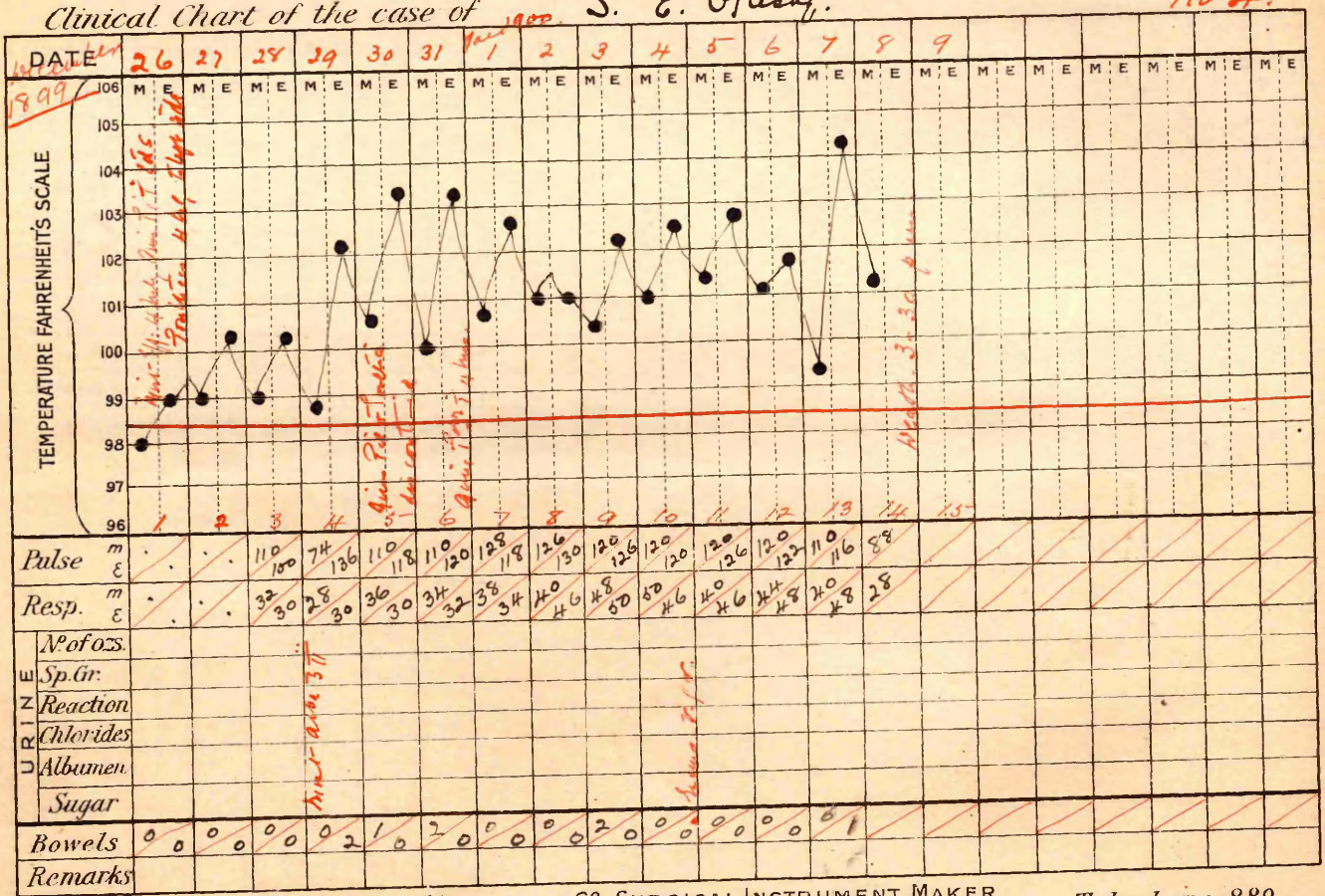
Bowels

Remarks

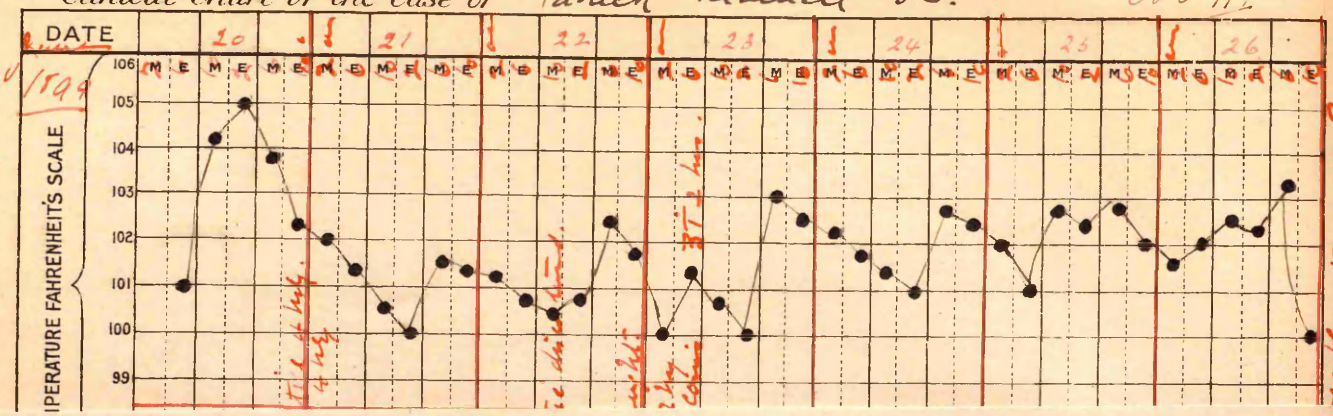
Clinical Chart of the case of Patrick Maxwell 56. No 111



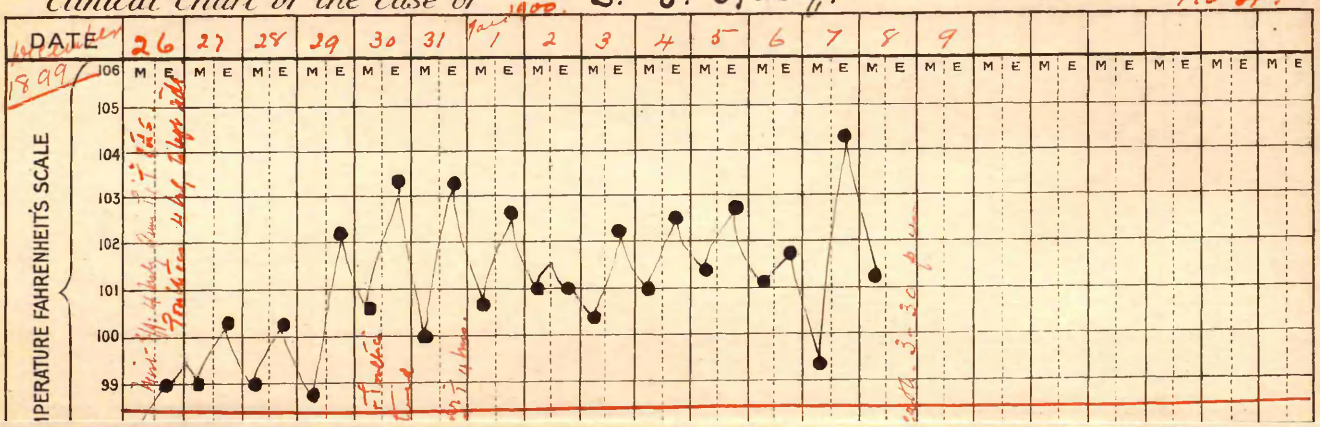
Clinical Chart of the case of S. E. Gluskey. No 4.



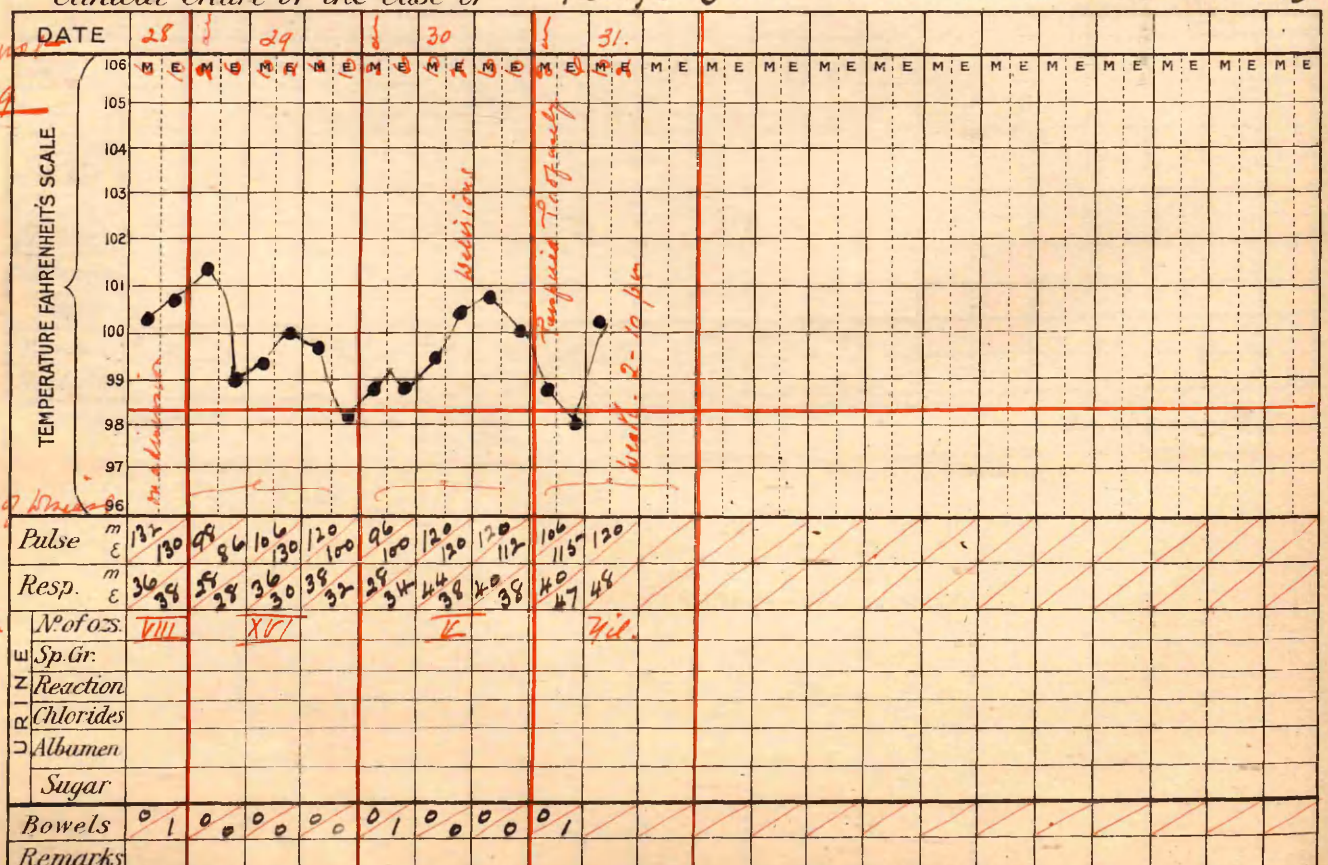
Clinical Chart of the case of Patrick Maxwell 56. No II.



Clinical Chart of the case of S. E. Oglesby. 1900. No 4.



Clinical Chart of the case of George Jones 61. Pneumonia No 5

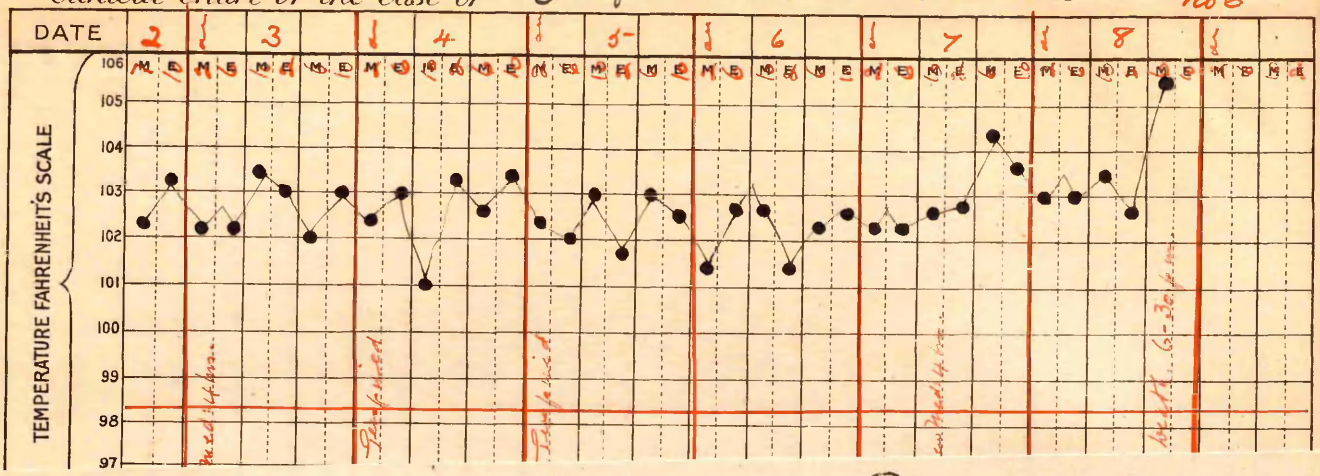


in good health the previous day and had had
rigors during the early morning on the day of admission
These cases represent a numerous class of cases
where there is a rigor & start with, and the temperature
runs up & a considerable height at once and then
maintains its height. In Chart No 2 there is an
exception of a rapid rise and the regains of hyperpyrexia
and then fall as rapid as fall there is a maximum
even temperature and the disease runs on with
little or no variation from that level
There is however another class of cases where the
temperature does not reach its maximum for three or
four days and then it is similar to the first class.
This is seen from Chart No. 4
There was still another variation that I particular and
chiefly in the case of the aged and is some heavy
drinkers and which is well shown in Chart No 5 where
the temperature never reaches such height as in the
first class but only reaches a moderate height
and soon falls into slightly febrile regions.
The course of the Chart exhibits numerous
variations
One type illustrated by Chart No. 6 runs along
at a considerable height and shows only
very little diurnal variation
Another type noted shows a remitting form of
fever and is illustrated by Chart No 7 where
in the course of 24 hours the temperature drops
from 104° to normal and within the
ensuing four hours rises to 104° and again
drops to normal. rises again to 105° and
at this point sponging was resorted to so

Clinical Chart of the case of Joseph Gibson. 45. Pneumonia No 6

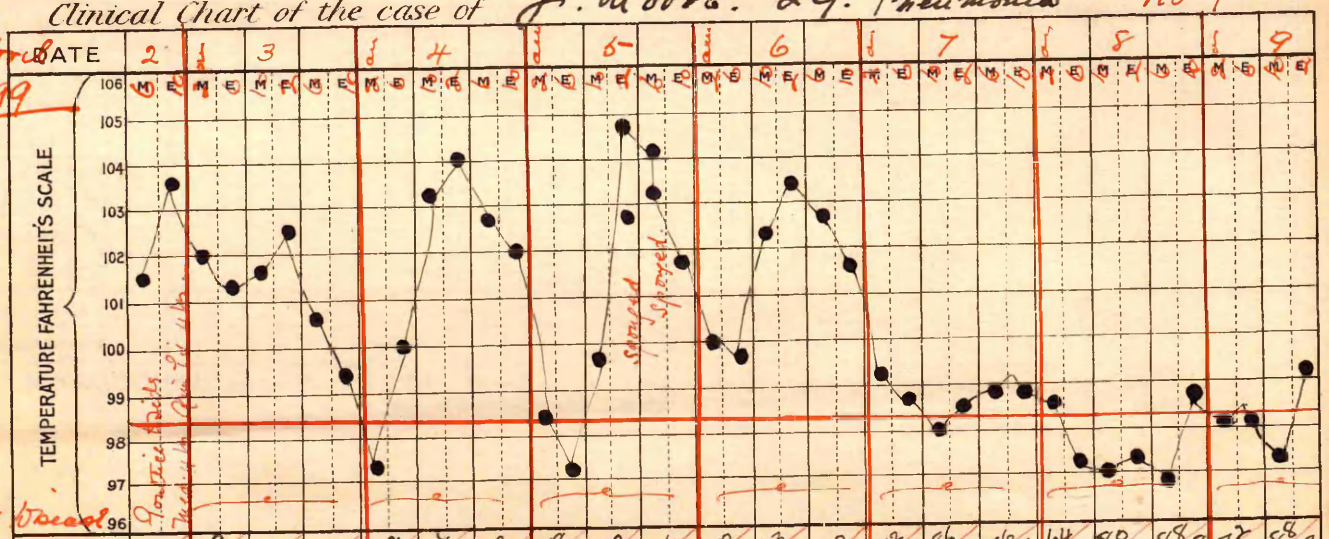
DATE	2		3		4		5		6		7		8			
	M	E	M	E	M	E	M	E	M	E	M	E	M	E	M	E
TEMPERATURE FAHRENHEIT'S SCALE 106	10		10	4		10		10		10		10		10		
105																
104																
103																
102																
101																
100																
99																
98																
97																
96	2		3		4		5		6		7		8			
Pulse m	120	118	118	120	118	118	120	118	120	120	124	120	128	128	128	130
Pulse E	112	116	116	120	122	124	120	116	120	120	124	128	124	130	130	136
Resp. m	40	38	36	38	36	40	44	38	60	36	46	50	50	50	50	58
Resp. E	36	37	38	38	42	42	42	38	50	50	48	50	50	52	52	62
URINE No of ozs.																
URINE Sp.Gr.																
URINE Reaction																
URINE Chlorides																
URINE Albumen																
URINE Sugar																
Bowels	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Remarks																

Clinical Chart of the case of Joseph Gibson. 45. Pneumonia No 6



Clinical Chart of the case of J. Moore. 29. Pneumonia No 7.

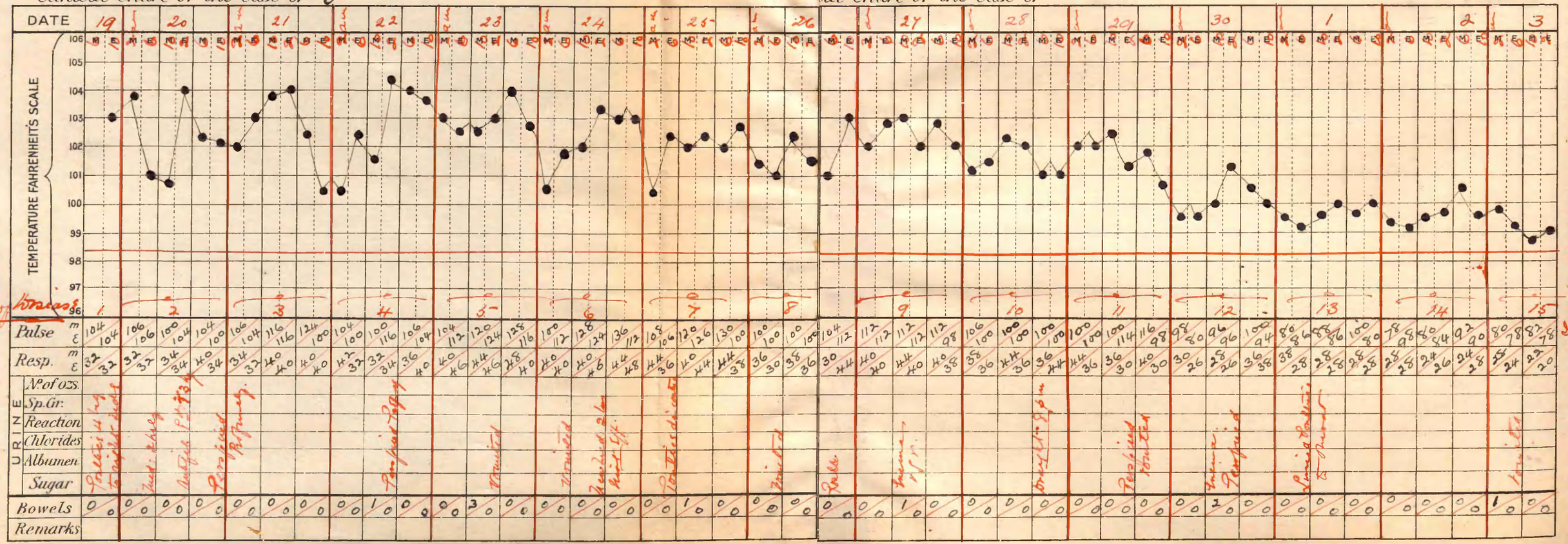
April 1899



day of disease

| | | |

Clinical Chart of the case of James Borland. 42 Tremonia No 8. Clinical Chart of the case of



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the next fall is not quite so reliable but it came down to 100° During the next twenty four hours it rose again to 103.2 and then fell to the normal and continued so until recovery was complete. There was no history of malaria in this case

Another type observed was when the temperature does not come down to normal but in every twenty four hours it runs over a considerable range. This is well illustrated by Chart No. 8 where a very irregular appearance is presented I have observed this appearance in at least three cases now and in each individual case there was always a strong suspicion that the pneumonia had been implanted on a tuberculous lung as the lungs both gave considerable time to clear up and even then were not quite satisfactory but the temperature came to normal and presented no elevation for some lengthened period after the illness. The case from which Chart No 8 was taken was ultimately readmitted with well marked phthisical symptoms

Another peculiarity noted during the course of the disease was that sharp falls (pseudocrisis) would occasionally take place and the crisis was thought to have come when just as suddenly the temperature would rise again and continue its former course for some time longer, although in some cases it did not reach its former height. This is well shown in Chart No. 9 where between the fourth and fifth days of disease the temperature fell

Clinical Chart of the case of Charles. Curtis 44. Pneumonia No 9.

March. 1898

DATE	29		30		31		April 1		2		3		4		5
	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M
Pulse m	84	112	110	82	86	99	96	96	112	110	100	96	90	71	82	68	80	74	72	76
Pulse ε		112	104	88	93	100	80	106	96	116	100	100	80	82	47	76	86	82	85	74
Resp. m	27	44	37	35	32	36	45	48	46	54	60	58	56	40	25	60	40	44	62	35
Resp. ε		44	31	30	32	40	36	48	52	60	48	44	56	32	36	56	39	56	56	36
URINE No of ozs.																				
URINE Sp.Gr.																				
URINE Reaction																				
URINE Chlorides																				
URINE Albumen																				
URINE Sugar																				
Bowels	0 /	0 0	0 0	0 0	0 0	0 0	0 0	0 2	1 1	3 4	2 2	0 1	0 0	0 0	1 0	0 1	0 0	2 0	0 1	0 0	0
Remarks																				

Temperature. continued

Clinical Chart of the case of Charles Curtis 44. Pneumonia No 9.

March 1898

DATE	29		30		31		April 1		2		3		4		5
Pulse m	84	112	112	110	104	82	88	86	93	99	100	96	80	96	106
Pulse e															
Resp. m	27	44	44	37	31	25	30	32	32	36	40	45	36	48	48
Resp. e															
Urine No of ozs.															
Urine Sp.Gr.															
Urine Reaction															
Urine Chlorides															
Urine Albumen															
Urine Sugar															
Bowels	0	1	0	0	0	0	0	0	0	0	0	0	2	1	1
Remarks															

DATE	6		7		8		9		10		11	
Pulse m	112	110	96	110	116	110	100	100	96	100	90	80
Pulse e												
Resp. m	46	52	54	60	60	48	58	44	56	56	40	32
Resp. e												
Urine No of ozs.												
Urine Sp.Gr.												
Urine Reaction												
Urine Chlorides												
Urine Albumen												
Urine Sugar												
Bowels	3	4	2	2	0	1	0	0	0	0	1	0
Remarks												

DATE	12		13		14		15		16		17	
Pulse m	96	100	96	80	71	87	82	92	68	76	80	96
Pulse e												
Resp. m	25	36	60	56	40	39	44	56	62	56	62	48
Resp. e												
Urine No of ozs.												
Urine Sp.Gr.												
Urine Reaction												
Urine Chlorides												
Urine Albumen												
Urine Sugar												
Bowels	0	1	0	0	2	0	0	1	0	0	0	0
Remarks												

Temperature continued normal

Clinical Chart of the case of James McAndrew, 73. Pneumonia. No 10

DATE	10		11		12		13		14		15		16		17
Pulse m	106	120	100	100	112	108	112	128	120	120	112				
Pulse e	192														
Resp. m	58	48	40	48	48	54	56	48	48	52	64	62			
Resp. e	58	48	48												
Urine No of ozs.															
Urine Sp.Gr.															
Urine Reaction															
Urine Chlorides															
Urine Albumen															
Urine Sugar															
Bowels	0	0	0	0	2	0	0	0	0	0	0				
Remarks															

Period of Invasion 24 hrs

Day of Disease

from 102° to 99 but it soon rose again and in the evening reached 103° and continued so for other three days when the true crisis came

I did not notice that these sharp falls, in any way interfered with the usual course of the disease nor could I make out any cause for them, apparently they occurred spontaneously

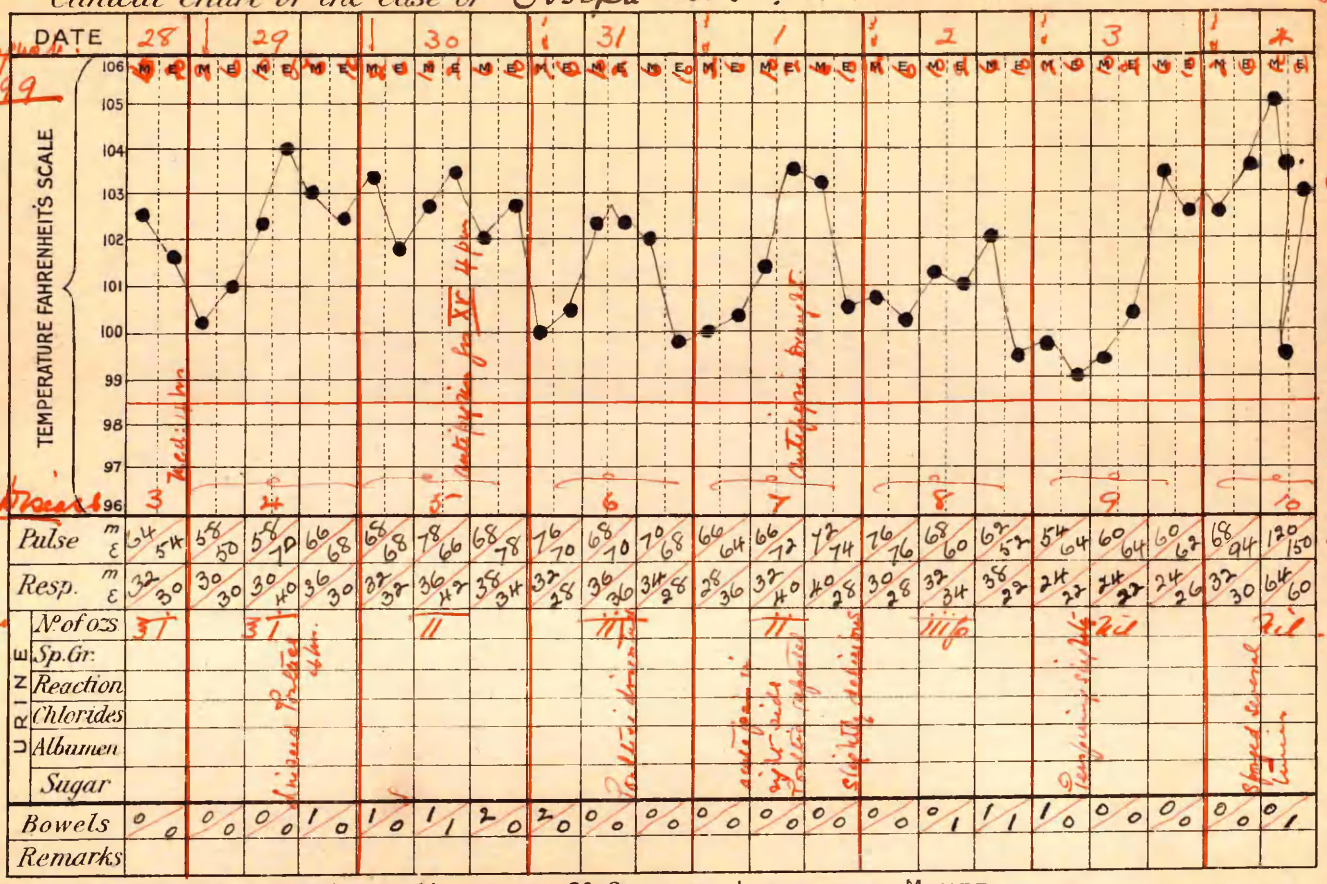
I now come to deal with the termination of the fever. This as a rule came on from the fifth to the seventh day of disease but was often prolonged to the tenth and in Chart No 8 it was prolonged to the fifteenth day

The earliest day at which I noticed the temperature falling to normal was the second This is shown in Chart No 10

The mode of termination was, as a rule, by a crisis, more or less well marked. Chart No 1 gives a fair example of a crisis when the temperature dropped from 102 to 97·5. I did not meet with a case which dropped from any higher elevation to normal Chart No 8 furnishes a good example of a case ending by a lysis in contrast to the usual termination

The crisis sometimes was complete within twelve hours but more often it took from twenty four to forty eight hours and sometimes even longer When the fall was rapid I have noted the temperature getting as low as 96° but I never saw any ill effects from this as the temperature soon rose again On the other hand instead of having a favourable termination the disease often ended fatally and I noted occasionally

Clinical Chart of the case of Joseph Moss. 44. Pneumonia. No 11



August 1879

Death. 12.50 am. September 5th 1879

Day of Disease

Specimen

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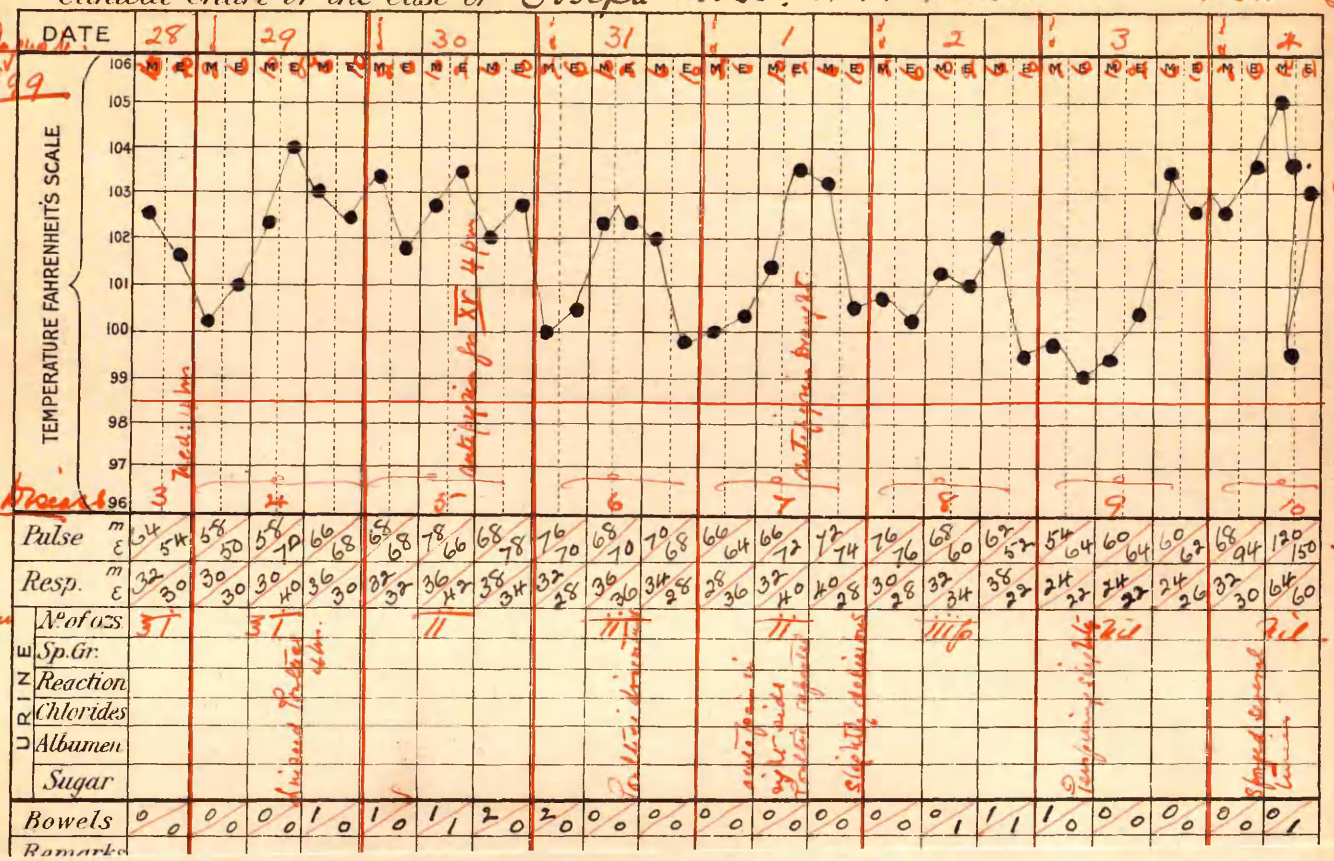
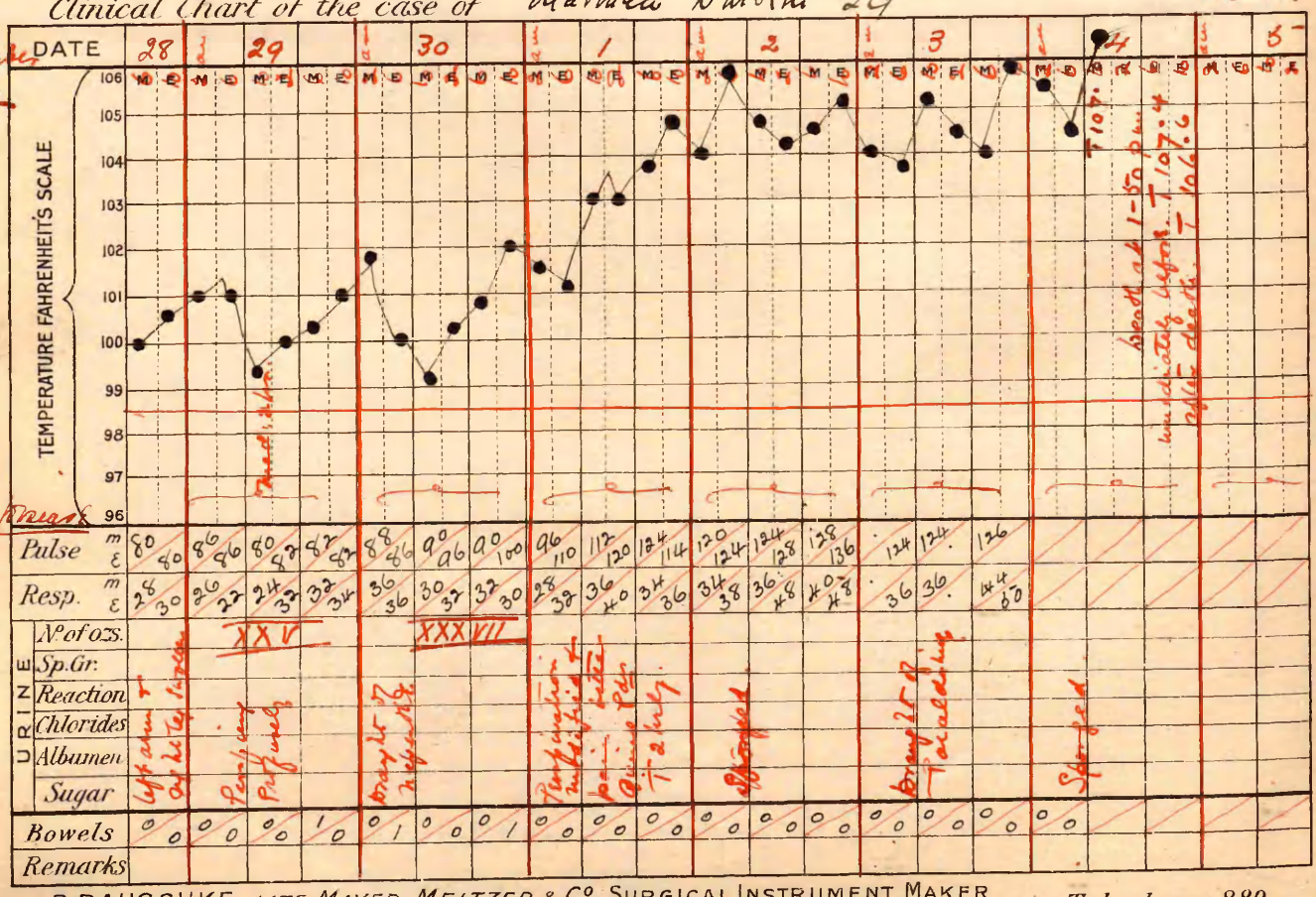
Clinical Chart of the case of Joseph Moss. 44. Pneumonia. No 11



Clinical Chart of the case of Mathew Burns 29. No 12.



the exact reverse to the crisis Instead of the temperature coming down just before death it would mount up just as rapidly, or more so as it would fall in the most distinct crisis In Chart No 11 on or day preceding death the temperature in the morning came down to 99° and the crisis was thought to have come but within eight hours it had risen again to 103·4 and in other eight hours it reached 105. at this point the patient was stimulated and the temperature fell almost directly to 99° but in two hours after it had reached 103° & the patient succumbed.
Again in Chart No 2 a fourth period rise is noted just before death
In Chart No 6 the temperature reached 106°. I have only met with so high temperature once and that was in the case of Chart No 12 when just prior to death it reached 107°.4 In each of these cases delirium was a prominent feature and it was in those cases when nervous symptoms were prominent that those rises occurred before death. In Chart No 11 meningitis came on as a complication.
As in recovery all cases do not end by a sharp crisis so in death all cases do not terminate by a rapid ascent of the temperature There were cases where the patient died from suffocation or from heart failure when the temperature remained practically steady up to the time of death. In some others a fall of a few degrees was noted

Clinical Chart of the case of Clifford Ratcliffe 27. Pneumonia No 13.

May 1899

DATE	2		3		4		5		6		7		8		9	
	M	E	M	E	M	E	M	E	M	E	M	E	M	E	M	E
Pulse m	102	140	120	130	126	140	118	122	118	100	96	86	98	78	96	80	96	76	86	80	82	84
Pulse e			117	120	132	126	140	124	112	103	100	104	100	96	86	96	90	100	100	96		78
Resp. m	37	42	42	40	46	52	46	50	40	40	40	36	40	38	36	40	24	30	28	28	26	24
Resp. e			56	50	46	48	56	48	50	43	40	39	48	46	46	36	24	38	30		26	22
URINE No of ozs.																						
URINE Sp.Gr.																						
URINE Reaction																						
URINE Chlorides																						
URINE Albumen																						
URINE Sugar																						
Bowels	0		3	3	0	7	0	4	0	0	0	0	0	0	1	0	1	0	0	1	0	0	2	0	1	0	1	0	1
Remarks																						

TEMPERATURE FAHRENHEIT'S SCALE

106 105 104 103 102 101 100 99 98 97 96

Day of Disease 6 7 8 9 10 11 12

Temperature continued normal.

Clinical Chart of the case of Clifford Ratcliffe 27. Pneumonia No 13.

May 1890

DATE 2 3 4 5 6 7 8 9

TEMPERATURE FAHRENHEIT'S SCALE

Way of Disease

Pulse m 102 120 130 120 126 140 118 122 118 100 96 86 98 78 86 80 76 86 79 80 84
ε 140 112 120 130 132 126 140 122 112 103 100 104 100 96 96 96 90 100 100 82 78

Resp. m 37 42 40 50 40 52 46 50 40 40 36 40 38 36 40 24 30 28 28 28
ε 42 56 50 52 46 48 56 48 50 43 40 39 48 46 46 36 24 38 30 26 22

URINE
No of ozs.
Sp.Gr.
Reaction
Chlorides
Albumen
Sugar

Bowels 0 3 3 0 7 0 4 0 0 4 0 0 0 0 0 1 0 0 1 0 0 1 0 0 2 0 1 0 1 0 1
Remarks

Temperatures continued overleaf.

Clinical Chart of the case of John Hart 62. Pneumonia No 14.

May 1890

DATE 24 25 26 27 28 29 30 31 1 2 3 4 5 6 7 8 9 10 11 12 13

TEMPERATURE FAHRENHEIT'S SCALE

Way of Disease

Pulse m 112 106 96 88 80 74 78 80 84 64 82 82 90 90 84 84 84 88 84 100 76 72 74 74
ε 116 110 104 94 76 76 78 96 100 100 72 90 90 80 80 84 84 84 100 76 84 84 78

Resp. m 40 42 54 52 42 40 32 38 44 36 20 38 38 20 22 24 40 45 45 28 36 34
ε 46 52 60 44 34 40 36 42 38 46 30 38 44 20 36 44 34 36 30 36 34

URINE
No of ozs.
Sp.Gr.
Reaction
Chlorides
Albumen
Sugar

Bowels 0 0 0 1 0 0 1 0 6 0 0 1 0 0 0 1 0 0 0 1 0 0 0 0 0 0 1 0 1 0 1
Remarks

During the first two or three days of convalescence I have noted, in some cases that is a considerable rise of temperature. This is illustrated by chart No 13 where on three successive days following the crisis a rise of 2,00 was noted and after that the temperature kept normal. The same is shown in chart No 9. These evening rises not being continued over a longer period than three days did not in any way interfere with convalescence and were probably due to an excess of the normal daily variation brought about by the weakened condition of the patient.

The evening rise after convalescence has begun was a fairly common occurrence and is to be carefully distinguished from those cases where the chart shows the temperature running up into febrile regions and remaining there some days and then coming down to normal again by a crisis. This is shown to a certain extent in chart No 14 where the temperature had been normal for about forty eight hours and then it began to rise until it reached 102°. The next few days show much irregularity but it comes down at the end by a crisis. In this case with all along showed a very irregular chart there was a suspicion of phthisis and that might have accounted for the secondary elevation or what is quite as probable is that the secondary fever was due to a fresh extension of the inflammatory process.